FOR OHF USE

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0034694

Facility Name: Oakbrook Healthcare Centre

Address: 2013 Midwest Road (Number) Oak Brook (City) 60523 (Zip Code)

County: DuPage

Telephone Number: (630) 495-0220 **Fax #** (630) 495-9150

IDPA ID Number: #36-3601135-001

Date of Initial License for Current Owners: 09/07/88

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Christopher Vicere **Telephone Number:** (773) 604-4416

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1-Jan-02 to 31-Dec-02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) 28-March-2003 (Date)
(Type or Print Name) Christopher Vicere
(Title) Vice President - Finance

Paid Preparer

(Signed) (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Oakbrook Healthcare Centre # 0034694 Report Period Beginning: 1-Jan-02 Ending: 31-Dec-02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	128	Skilled (SNF)	128	46,720	1
2		Skilled Pediatric (SNF/PED)			2
3	28	Intermediate (ICF)	28	10,220	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	156	TOTALS	156	56,940	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	11,996	5,766	5,142	22,904	8
9	SNF/PED					9
10	ICF	18,187	11,184	112	29,483	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	30,183	16,950	5,254	52,387	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.00%

D. How many bed-hold days during this year were paid by Public Aid?
171 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started September 7, 1988

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date October 26, 1988 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 128 and days of care provided 4,708

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/02 Fiscal Year: 12/31/02

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Oakbrook Healthcare Centre # 0034694 Report Period Beginning: 1-Jan-02 Ending: 31-Dec-02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	263,343	33,954	11,280	308,577		308,577		308,577			1
2	Food Purchase		233,387		233,387	(10,348)	223,039	(724)	222,315			2
3	Housekeeping	320,273	57,618		377,891		377,891		377,891			3
4	Laundry	73,415	39,406	1,813	114,634		114,634		114,634			4
5	Heat and Other Utilities			159,830	159,830		159,830		159,830			5
6	Maintenance	68,409	30,967	67,278	166,654		166,654	1,076	167,730			6
7	Other (specify):*											7
8	**TOTAL General Services**	725,440	395,332	240,201	1,360,973	(10,348)	1,350,625	352	1,350,977			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	2,259,121	165,210	212,818	2,637,149		2,637,149		2,637,149			10
10a	Therapy			11,513	11,513		11,513		11,513			10a
11	Activities	125,144	15,648	2,304	143,096		143,096		143,096			11
12	Social Services	65,283		5,556	70,839		70,839		70,839			12
13	Nurse Aide Training		822		822		822		822			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,449,548	181,680	250,191	2,881,419		2,881,419		2,881,419			16
	C. General Administration											
17	Administrative	133,653		187,200	320,853		320,853	(147,990)	172,863			17
18	Directors Fees											18
19	Professional Services			32,222	32,222		32,222	10,153	42,375			19
20	Dues, Fees, Subscriptions & Promotions			22,053	22,053		22,053	22,144	44,197			20
21	Clerical & General Office Expenses	90,412	39,364	56,296	186,072		186,072	58,921	244,993			21
22	Employee Benefits & Payroll Taxes			470,957	470,957	10,348	481,305	21,708	503,013			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,553	5,553		5,553	6,083	11,636			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			49,525	49,525		49,525	39,195	88,720			26
27	Other (specify):*							9,076	9,076			27
28	**TOTAL General Administration**	224,065	39,364	823,806	1,087,235	10,348	1,097,583	19,290	1,116,873			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,399,053	616,376	1,314,198	5,329,627		5,329,627	19,642	5,349,269			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Oakbrook Healthcare Centre #0034694 Report Period Beginning: 1-Jan-02 Ending: 31-Dec-02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			83,426	83,426		83,426	224,457	307,883			30
31	Amortization of Pre-Op. & Org.							6,699	6,699			31
32	Interest			288,000	288,000		288,000	519,499	807,499			32
33	Real Estate Taxes			61,591	61,591		61,591		61,591			33
34	Rent-Facility & Grounds			1,742,712	1,742,712		1,742,712	(1,740,000)	2,712			34
35	Rent-Equipment & Vehicles			2,310	2,310		2,310		2,310			35
36	Other (specify):*											36
37	**TOTAL Ownership**			2,178,039	2,178,039		2,178,039	(989,345)	1,188,694			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		193,445	173,759	367,204		367,204		367,204			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			85,410	85,410		85,410		85,410			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		193,445	259,169	452,614		452,614		452,614			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,399,053	809,821	3,751,406	7,960,280		7,960,280	(969,703)	6,990,577			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Oakbrook Healthcare Centre # 0034694 Report Period Beginning: 1-Jan-02 Ending: 31-Dec-02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	71,187	30		9
10	Interest and Other Investment Income	(15,579)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(724)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(15,429)	21		24
25	Fund Raising, Advertising and Promotional	(5,420)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(3,431)	20		28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 30,604		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(1,000,307)	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (1,000,307)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (969,703)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Oakbrook Healthcare Centre

ID# 0034694

Report Period Beginning: 1-Jan-02

Ending: 31-Dec-02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Oakbrook Healthcare Centre # 0034694 Report Period Beginning: 1-Jan-02 Ending: 31-Dec-02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(724)	0	0	0	0	0	0	0	0	0	0	(724)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	1,076	0	0	0	0	0	0	0	0	0	1,076	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(724)	1,076	0	0	0	0	0	0	0	0	0	352	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(147,990)	0	0	0	0	0	0	0	0	0	(147,990)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	10,153	0	0	0	0	0	0	0	0	0	10,153	19
20	Fees, Subscriptions & Promotions	(8,851)	30,995	0	0	0	0	0	0	0	0	0	22,144	20
21	Clerical & General Office Expenses	(15,429)	74,350	0	0	0	0	0	0	0	0	0	58,921	21
22	Employee Benefits & Payroll Taxes	0	21,708	0	0	0	0	0	0	0	0	0	21,708	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	6,083	0	0	0	0	0	0	0	0	0	6,083	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	39,195	0	0	0	0	0	0	0	0	39,195	26
27	Other (specify):*	0	9,076	0	0	0	0	0	0	0	0	0	9,076	27
28	**TOTAL General Administration**	(24,280)	4,375	39,195	0	0	0	0	0	0	0	0	19,290	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(25,004)	5,451	39,195	0	0	0	0	0	0	0	0	19,642	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number Oakbrook Healthcare Centre **#** 0034694 **Report Period Beginning:** 1-Jan-02 **Ending:** 31-Dec-02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	71,187	1,522	151,748	0	0	0	0	0	0	0	0	224,457	30
31	Amortization of Pre-Op. & Org.	0	0	6,699	0	0	0	0	0	0	0	0	6,699	31
32	Interest	(15,579)	43,732	491,346	0	0	0	0	0	0	0	0	519,499	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(1,740,000)	0	0	0	0	0	0	0	0	(1,740,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	55,608	45,254	(1,090,207)	0	0	0	0	0	0	0	0	(989,345)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	30,604	50,705	(1,051,012)	0	0	0	0	0	0	0	0	(969,703)	45

Facility Name & ID Number Oakbrook Healthcare Centre # 0034694 Report Period Beginning: 1-Jan-02 Ending: 31-Dec-02

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Oficers' Salaries	$	Lancaster, Ltd.	100.00%	$ 36,740	$ 36,740	1
2	V	27	Payroll Taxes-Officers		Lancaster, Ltd.	100.00%	1,877	1,877	2
3	V	17	Management Fee Income	187,200	Lancaster, Ltd.	100.00%		(187,200)	3
4	V	19	Professional Services		Lancaster, Ltd.	100.00%	10,153	10,153	4
5	V	21	Clerical Expenses		Lancaster, Ltd.	100.00%	74,350	74,350	5
6	V	22	Employee benefits		Lancaster, Ltd.	100.00%	21,708	21,708	6
7	V	24	Education and Seminars		Lancaster, Ltd.	100.00%	6,083	6,083	7
8	V	17	Administrative Consultant		Lancaster, Ltd.	100.00%	2,470	2,470	8
9	V	20	Fees and Marketing		Lancaster, Ltd.	100.00%	30,995	30,995	9
10	V	32	Interest		Lancaster, Ltd.	100.00%	43,732	43,732	10
11	V	30	Depreciation		Lancaster, Ltd.	100.00%	1,522	1,522	11
12	V	6	Maintenance		Lancaster, Ltd.	100.00%	1,076	1,076	12
13	V	27	Payroll Taxes-Clerical		Lancaster, Ltd.	100.00%	7,199	7,199	13
14	Total			$ 187,200			$ 237,905	$ * 50,705	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Oakbrook Healthcare Centre # 0034694 Report Period Beginning: 1-Jan-02 Ending: 31-Dec-02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	Rental	$ 1,740,000	OakBrook Associates	100.00%	$	$ (1,740,000)	15
16	V	32	Interest	32,692	OakBrook Associates	100.00%	524,038	491,346	16
17	V	30	Depreciation		OakBrook Associates	100.00%	151,748	151,748	17
18	V	31	Amortization		OakBrook Associates	100.00%	6,699	6,699	18
19	V	26	Mortgage Insurance Premium		OakBrook Associates	100.00%	39,195	39,195	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 1,772,692			$ 721,680	$ * (1,051,012)	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Oakbrook Healthcare Centre # 0034694 Report Period Beginning: 1-Jan-02 Ending: 31-Dec-02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Laurence Zung	Executive Officer	Administrative	33.33%	See Attched	2	4.17%	Lancaster	$ 14,679	17-7	1
2	Christopher Vicere	VP-Finance	Administrative	0.00	See Attched	5	10.42%	Lancaster	12,906	17-7	2
3	Cheryl Morris	VP-Operations	Administrative	0.00	See Attched	5	10.42%	Lancaster	9,155	17-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 36,740		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Oakbrook Healthcare Centre # 0034694 Report Period Beginning: 1-Jan-02 Ending: 31-Dec-02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Lancaster, Ltd.
Street Address: 5061 N. Pulaski Road
City / State / Zip Code: Chicago, IL 60630
Phone Number: ((773) 478-3699
Fax Number: ((773) 478-1192

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Laurence Zung	Hours Worked	48	7	$ 352,300	$ 352,300	2	$ 14,679	1
2	27	Laurence Zung	Hours Worked	48	7	10,482	0	2	437	2
3	17	Christopher Vicere	Hours Worked	48	7	123,902	123,902	5	12,906	3
4	27	Christopher Vicere	Hours Worked	48	7	7,171	0	5	747	4
5	17	Cheryl Morris	Hours Worked	48	7	87,889	87,889	5	9,155	5
6	27	Cheryl Morris	Hours Worked	48	7	6,648	0	5	693	6
7										7
8										8
9	19	Professional Services	Management Fees	1,611,600	7	87,404	0	187,200	10,153	9
10	21	Clerical Expenses	Management Fees	1,611,600	7	35,722	0	187,200	4,149	10
11	22	Employee Benefits	Management Fees	1,611,600	7	186,880	0	187,200	21,708	11
12	24	Education and Seminars	Management Fees	1,611,600	7	11,327	0	187,200	1,316	12
13	17	Administrative Consultant	Management Fees	1,611,600	7	21,265	0	187,200	2,470	13
14	20	Marketing	Management Fees	1,611,600	7	251,556	174,958	187,200	29,220	14
15	32	Interest	Management Fees	1,611,600	7	11,616	0	187,200	1,349	15
16	30	Depreciation	Management Fees	1,611,600	7	13,099	0	187,200	1,522	16
17	20	Licenses and Fees	Management Fees	1,611,600	7	15,277	0	187,200	1,775	17
18	6	Maintenance	Management Fees	1,611,600	7	9,263	0	187,200	1,076	18
19	24	Travel	Management Fees	1,611,600	7	41,037	0	187,200	4,767	19
20	21	Salaries-Clerical	Management Fees	1,611,600	7	604,357	604,357	187,200	70,201	20
21	27	Payroll Taxes-Clerical	Management Fees	1,611,600	7	61,975	0	187,200	7,199	21
22										22
23	32	Direct Interest							42,383	23
24										24
25	TOTALS					$ 1,939,170	$ 1,343,406		$ 237,905	25

Facility Name & ID Number Oakbrook Healthcare Centre # 0034694 Report Period Beginning: 1-Jan-02 Ending: 31-Dec-02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Cambridge Reality Capital		X	Mortgage	$49,956.72	11/1/98	$ 8,152,700	$ 7,875,213	11/30/34		$ 524,038	1
2												2
3												3
4												4
5												5
	Working Capital											
6	American Nat'l (BankOne)		X	Working Capital							1,349	6
7	Harston Investments		X	Working Capital							288,000	7
8												8
9	TOTAL Facility Related				$49,956.72		$ 8,152,700	$ 7,875,213			$ 813,387	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 8,152,700	$ 7,875,213			$ 813,387	15
										Less Interest Income	(5,889)	
										Adj. Total	807,498	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Oakbrook Healthcare Centre # 0034694 Report Period Beginning: 1-Jan-02 Ending: 31-Dec-02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2001 report.	$	60,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	60,491	2
3. Under or (over) accrual (line 2 minus line 1).	$	491	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)	$	61,100	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	61,591	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1997	56,070	8
	1998	56,523	9
	1999	57,645	10
	2000	58,818	11
	2001	60,491	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Oakbrook Healthcare Centre COUNTY DuPage

FACILITY IDPH LICENSE NUMBER 0034694

CONTACT PERSON REGARDING THIS REPORT Christopher Vicere

TELEPHONE (773) 604-4416 FAX #: (773) 478-1192

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	06-22-303-035	Long-Term Healthcare	$ 60,491.00	$ 60,491.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 60,491.00	$ 60,491.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number Oakbrook Healthcare Centre # 0034694 Report Period Beginning: 1-Jan-02 Ending: 31-Dec-02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior Brick Frame _____ Number of Stories _____

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 234,464
2. Number of Years Over Which it is Being Amortized: 35
3. Current Period Amortization: 6,699
4. Dates Incurred: 26-Oct-98

Nature of Costs: Pre-Operating
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Care Facility		1998	$ 830,000	1
2					2
3	TOTALS			$ 830,000	3

Facility Name & ID Number Oakbrook Healthcare Centre # 0034694 Report Period Beginning: 1-Jan-02 Ending: 31-Dec-02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	154				$ 3,586,000	$ 91,949	40	$ 91,947	$ (2)	$ 417,600	4
5	144		1992	1994	1,863,459	59,157	35	59,161	4	566,436	5
6	10		1994		25,000	641	35	641		6,001	6
7											7
8											8
	Improvement Type**										
9	Various			1988	8,828	286	20	449	163	7,381	9
10	Various			1989	92,298	3,426	20	4,551	1,125	62,823	10
11	Various			1990	24,448	595	20	1,166	571	13,730	11
12	Various			1991	2,212	70	15	111	41	995	12
13	Various			1992	1,275,149	40,483	20	65,479	24,996	600,437	13
14	Various			1993	289,021	6,465	15	16,089	9,624	127,044	14
15	Various			1994	10,459	317	15	618	301	3,761	15
16	Various			1995	52,918	473	15	923	450	11,540	16
17	Room #112 remodeling			1996	2,285	59	15	114	55	743	17
18	Nurses' call station			1996	10,545	270	15	527	257	3,081	18
19	Ceramic tiled bathroom and tub room			1996	15,362	394	20	768	374	4,554	19
20	Rehab room			1997	31,848	817	15	1,592	775	8,644	20
21	Fire doors			1997	3,013	77	15	151	74	819	21
22	Physical Therapy room			1997	6,749	173	15	337	164	1,830	22
23	12 bathrooms vented			1997	8,670	222	15	434	212	2,247	23
24	Roof improvements			1997	7,150	183	15	358	175	1,794	24
25	Excelon vinyl tiles - 1st floor			1997	15,600	400	15	780	380	3,715	25
26	Excelon vinyl tiles - 1st floor			1998	6,204	159	15	310	151	1,399	26
27	New roof			1998	3,850	99	15	193	94	527	27
28	Custom cabinets			1998	3,285	84	15	164	80	448	28
29	Fire alarm switch			1998	6,996	179	15	350	171	909	29
30	3 shower rooms rehab			1999	15,560	399	15	778	379	1,892	30
31	Hot water heater			1999	7,269	186	15	363	177	805	31
32	Parking lot asphalt			1999	28,900	741	15	1,445	704	3,328	32
33	Rehab resident rooms			1999	17,825	457	15	891	434	1,976	33
34	Aquarium			2001	4,441	114	15	114		195	34
35	Picture window			2001	14,403	369	15	369		600	35
36	Wander guard system			2001	17,385	4,258	15	4,258		6,742	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Oakbrook Healthcare Centre # 0034694 Report Period Beginning: 1-Jan-02 Ending: 31-Dec-02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Carpet - bookkeeping & lounge	2001	$ 2,715	$ 70	15	$ 70	$	$ 114	37
38	Vinyl tiles hallway	2001	9,815	252	15	252		305	38
39	Auto door	2002	2,340	728	15	78	(650)	78	39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 7,472,002	$ 214,552		$ 255,831	$ 41,279	$ 1,864,493	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Oakbrook Healthcare Centre # 0034694 Report Period Beginning: 1-Jan-02 Ending: 31-Dec-02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 267,694	$ 2,960	$ 34,966	$ 32,006	10	$ 125,763	71
72	Current Year Purchases	44,786	19,186	3,056	(16,130)	10	3,056	72
73	Fully Depreciated Assets	573,426		14,032	14,032	10	573,426	73
74								74
75	TOTALS	$ 885,906	$ 22,146	$ 52,054	$ 29,908		$ 702,245	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 9,187,908	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 236,698	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 307,885	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 71,187	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,566,738	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: ***N/A - Related Party Lease***

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5		***Off-site Public Storage Space***			2,712			5
6								6
7	TOTAL				$ 2,712 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 2,310 Description: $192.50 / month for Toshiba Copier
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Oakbrook Healthcare Centre # 0034694 Report Period Beginning: 1-Jan-02 Ending: 31-Dec-02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 63,384	$		$ 63,384	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			4,859			4,859	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			70,393			70,393	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				141,716		141,716	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Inhalation Therapy Other (specify): Med Sup/Sp Bed	39-3 39-2				35,123	51,729		35,123 51,729	13
14	TOTAL			$		$ 173,759	$ 193,445		$ 367,204	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Oakbrook Healthcare Centre # 0034694 **Report Period Beginning:** 1-Jan-02 **Ending:** 31-Dec-02

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 31-Dec-02 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 118,512	$ 2,481,734	1
2	Cash-Patient Deposits	26,707	26,707	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,087,572	1,087,572	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	36,123	36,123	6
7	Other Prepaid Expenses	6,586	335,960	7
8	Accounts Receivable (owners or related parties)	384,610	384,610	8
9	Other(specify): Employee advances	6,746	6,746	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,666,856	$ 4,359,452	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		830,000	13
14	Buildings, at Historical Cost		3,586,000	14
15	Leasehold Improvements, at Historical Cost	1,949,153	3,837,612	15
16	Equipment, at Historical Cost	745,214	865,869	16
17	Accumulated Depreciation (book methods)	(1,272,769)	(2,430,470)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		234,464	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(27,913)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,421,598	$ 6,895,562	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,088,454	$ 11,255,014	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 134,622	$ 134,623	26
27	Officer's Accounts Payable		2,592	27
28	Accounts Payable-Patient Deposits	31,090	31,090	28
29	Short-Term Notes Payable	76,476	156,628	29
30	Accrued Salaries Payable	82,448	82,448	30
31	Accrued Taxes Payable (excluding real estate taxes)	11,963	11,963	31
32	Accrued Real Estate Taxes(Sch.IX-B)	61,100	61,100	32
33	Accrued Interest Payable		43,478	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 397,699	$ 523,922	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	2,400,000	2,400,000	39
40	Mortgage Payable		7,795,061	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,400,000	$ 10,195,061	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,797,699	$ 10,718,983	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 290,755	$ 536,031	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,088,454	$ 11,255,014	48

***(See instructions.)**

Facility Name & ID Number Oakbrook Healthcare Centre # 0034694 Report Period Beginning: 1-Jan-02 Ending: 31-Dec-02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 39,211	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 39,211	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	251,544	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 251,544	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 290,755	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number Oakbrook Healthcare Centre # 0034694 Report Period Beginning: 1-Jan-02 Ending: 31-Dec-02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,946,337)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,946,337)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,302,557	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	1,179,811	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 2,482,368	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 0	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 536,031	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Oakbrook Healthcare Centre # 0034694 Report Period Beginning: 1-Jan-02 Ending: 31-Dec-02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,357,469	1
2	Discounts and Allowances for all Levels	(965,492)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,391,977	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	571,318	6
7	Oxygen	976	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 572,294	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	148,960	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	20,854	19
20	Radiology and X-Ray	11,564	20
21	Other Medical Services	48,196	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 229,574	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	15,579	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 15,579	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending commissions	2,400	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,400	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,211,824	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,360,973	31
32	Health Care	2,881,419	32
33	General Administration	1,087,235	33
	B. Capital Expense		
34	Ownership	2,178,039	34
	C. Ancillary Expense		
35	Special Cost Centers	367,204	35
36	Provider Participation Fee	85,410	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,960,280	40
41	**Income before Income Taxes (line 30 minus line 40)****	251,544	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 251,544	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Oakbrook Healthcare Centre # 0034694 Report Period Beginning: 1-Jan-02 Ending: 31-Dec-02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,093	2,338	$ 2,338	$ 1.00	1
2	Assistant Director of Nursing	1,485	1,678	1,678	1.00	2
3	Registered Nurses	38,175	41,370	41,370	1.00	3
4	Licensed Practical Nurses	7,700	8,418	8,418	1.00	4
5	Nurse Aides & Orderlies	81,418	86,096	86,096	1.00	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,896	2,148	32,698	15.22	9
10	Activity Assistants	10,181	10,629	92,446	8.70	10
11	Social Service Workers	3,517	3,750	65,283	17.41	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	25,735	28,255	263,343	9.32	15
16	Dishwashers					16
17	Maintenance Workers	5,352	5,657	68,409	12.09	17
18	Housekeepers	32,089	35,961	320,273	8.91	18
19	Laundry	8,010	8,650	73,415	8.49	19
20	Administrator	2,045	2,238	89,571	40.02	20
21	Assistant Administrator	2,045	2,102	44,082	20.97	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,883	7,350	90,412	12.30	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,073	2,261	30,102	13.31	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	230,697	248,901	$ 1,309,934 *	$ 5.26	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	282	$ 11,280	1-3	35
36	Medical Director	450	18,000	9-3	36
37	Medical Records Consultant	105	4,128	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	226	11,513	10a-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	59	2,304	11-3	44
45	Social Service Consultant	145	5,556	12-3	45
46	Other(specify) Dementia Consult.	54	1,905	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,321	$ 54,686		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	3,194	$ 139,371	10-3	50
51	Licensed Practical Nurses	1,836	67,414	10-3	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	5,030	$ 206,785		53

Facility Name & ID Number Oakbrook Healthcare Centre # 0034694 Report Period Beginning: 1-Jan-02 Ending: 31-Dec-02

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Joanne Bedrosian	Administrator	N/A	$ 89,571
Rose Rivera	Asst. Adm.	N/A	44,082
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 133,653

B. Administrative - Other

Description	Amount
Management Fees-Lancaster, Ltd.	$ 187,200
TOTAL (agree to Schedule V, line 17, col. 3)	$ 187,200
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Health Data Systems	Data Processing	$ 9,107
Power Software Development	Data Processing	3,391
Stone, Pogrund & Korey	Legal	5,302
Lasko & Kocol	Legal	4,090
Winston & Strawn	Legal	1,365
Lawrence Schwartz	Legal	3,113
Joseph Panarese	Legal	582
Frost Ruttenberg & Rothblatt	Accounting	1,195
Richard Peelo	Accounting	2,250
Personnel Planners	Unemployment Tax Consult.	1,827
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 32,222

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 35,788
Unemployment Compensation Insurance	29,102
FICA Taxes	254,010
Employee Health Insurance	134,221
Employee Meals	10,348
Illinois Municipal Retirement Fund (IMRF)*	
Retirement Plan Contribution	10,458
Uniforms	1,784
Employment Fees	5,594
Lancaster Allocation	21,708
TOTAL (agree to Schedule V, line 22, col.8)	$ 503,013

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	822
Health Care Worker Background Check	
(Indicate # of checks performed)	4,220
Promotional Advertising	8,851
Dues & Subscriptions	4,219
Licenses and Fees	3,741
Lancaster Allocation	30,995
Less: Public Relations Expense	( )
Non-allowable advertising	(5,420)
Yellow page advertising	(3,431)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 44,197

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 1,318
In-State Travel	144
Seminar Expense	4,091
Lancaster Allocation	6,083
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 11,636

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Oakbrook Healthcare Centre # 0034694 Report Period Beginning: 1-Jan-02 Ending: 31-Dec-02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Oakbrook Healthcare Centre # 0034694 Report Period Beginning: 1-Jan-02 Ending: 31-Dec-02

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 yrs.**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **23,777** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **85,410**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **10,348** Has any meal income been offset against related costs? **No** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.